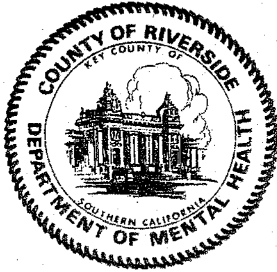

P O Box 7549
Riverside, Ca 92513
Phone: (951 955-7320
Fax: (951) 955-7203

Riverside County MH Outpatient Quality Improvement

This fax cover sheet must be completed and used when submitting a Medication Declaration.

Date: ____________________

To: Quality Improvement Outpatient

Fax # (951) 955-7203

From: ____________________

Address ____________________

Phone # ____________________

Fax # ____________________

Client Name: ____________________

Social Security # of client ____________________

Page 1 of ______ pages

PROPOSED TREATMENT AND FOLLOW UP SERVICES

Referral Source: ☐ ACT ☐ CAT ☐ TRACT

Psychiatric Evaluation ________ Session(s) per week/month for _______ weeks/months (15, 30, 60 min.)

Collateral Visit ____________ Session(s) per week/month for _______ weeks/months (30, 60 min.)

Collateral Sessions with: ____________________

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